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OPTOMETRIC GERONTOLOGY— CURRICULUM RECOMMENDATIONS

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Optometric Gerontology: State of the Art in Schools and Colleges of Optometry

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Gary L. Mancil, O.D.

Abstract

In 1984, Dr. Alfred Rosenbloom surveyed fifteen schools of optometry regarding academic and clinical coursework on optometric gerontology. A second survey was completed in winter 1986 by the ASCO Optometric Gerontology Curriculum Development Committee. This article will discuss the results of the committee's survey, make comparisons to the Rosenbloom survey and present the committee's recommendations for implementing a comprehensive optometric gerontology curriculum at each of the ASCO member institutions.

Introduction

In 1982, more than 26 million Americans were over the age of 65. This number is projected to be more than 35 million by the year 2000.[1] This group, representing only 11 percent of the U.S. population, consumes one-third of the nation's health care.[2] The need for responsive and appropriate health care is expected to grow as the elderly population increases in size. In order to successfully meet these needs, health care systems will require practitioners, educated and trained in caring for older adults.

Organized optometry, using the profession's specialized expertise, has provided vision services to elderly individuals for a long time. However, responding to the increased number of aging Americans, professional optometry has recently recognized the need to strengthen its training to meet the social, psychological and other health needs of the older person. Formal education in the health and vision needs of the elderly is frequently available at association meetings, college continuing education programs and at local, state and national professional meetings.

In 1984, the American Optometric Association applied for and received funding from the Administration on Aging to provide additional training to optometric practitioners serving the elderly. A continuing education program and a manual in optometric gerontology were developed, implemented and disseminated. The Vision Care Section of the American Public Health Association also recognized the need for greater training to provide services to the older adult. In a recent resolution, that organization "encourages multidisciplinary efforts in caring for the elderly's visual impairment so that visual needs are met within the context of the individual's daily activities."[3] These steps indicate the profession's increasing involvement in and dedication to the total care of elderly persons. In order to address the unique issues related to aging individuals, eye care professionals need a broad-based education in gerontology.

Providing health professional students with geriatric patient care experiences significantly impacts the attitudes of such future providers.[4,5] Dr. John Potter stated in an editorial for the *Journal of Optometric Education* (JOE), "Because there is a positive correlation between knowledge and attitudes, optometric faculty should consider early in their professional school curricula definite educational strategies to impart knowledge about the aging process and about the health care and social problems of the elderly."[6]

Recently, ASCO's Board of Directors reaffirmed optometry's commitment to enhancing the quality of education in optometric gerontology. An Optometric Gerontology Curriculum Development Committee was appointed by ASCO in spring 1986. The Committee's primary directive was to develop, implement and disseminate a comprehensive optometric gerontology curriculum designed to improve the knowledge and skills of future optometrists.

Dr. Alfred Rosenbloom had assessed, in 1984, the number of clinical and academic courses offered at the schools and colleges of optometry.[7] In fall 1986, the ASCO Optometric Gerontology Curriculum Development Committee designed and distributed a survey to update some findings of the Rosenbloom study and to explore additional areas.

Methods

A questionnaire was developed and distributed to 18 schools and colleges of optometry; 16 responses were received. Information was gathered in the following areas:

Dr. Aston is the chairperson of the Department of External Clinical Programs, coordinator of Programs in Aging and assistant professor at the Pennsylvania College of Optometry.

Dr. DeSylvia is director of clinical services at the Optometric Institute and Clinic of Detroit and assistant professor at Ferris State University College of Optometry.

Dr. Mancil, former assistant professor and geriatrics coordinator at the University of Alabama at Birmingham School of Optometry, is currently practicing optometry in Atlanta, Georgia.

- training of present primary contact faculty in geriatrics,
- number and type of formal optometric gerontology courses,
- types of on- and off-campus clinical activities,
- current vision and aging research projects,
- public education/health promotional activities in vision and aging,
- relevant continuing education programs, and
- optimal modes of optometric gerontology instruction.

Results

Question #1 of the survey asked for the name and educational background of a primary faculty/staff member active in the institution's didactic and/or clinical optometric gerontology program. Table 1 provides a summary of the formal geriatric training of the "primary contact" in each of the 16 responding institutions. Ten faculty members did not have any formal training, one had completed gerontology college coursework, three had rotated through the intensive gerontology courses for health care providers at regional Geriatric Education Centers, one held a gerontology certificate and one had a graduate level degree in social gerontology. Some respondents indicated limited continuing education courses in gerontology and related areas; however, because the content, quality, duration and structure were unknown, this type of training was not considered to be formal.

The next area surveyed concerned the type of didactic instruction on the subject of optometric gerontology (Table 2). Five schools did not have a separate formal course. Eight institutions had required courses, one for four hours per week, two for three hours per week and five for two hours per week. None of the nine courses had a laboratory component. Two colleges of optometry had formalized courses, although elective in nature. Most courses were of 10–12 weeks duration. The remaining school had a required, combined low vision and gerontology course with two hours lecture and two hours lab per week for 14 weeks. Three schools indicated plans to incorporate a required separate course on optometric gerontology into the curriculum by December 1988.

Opportunities for training in clinical geriatrics were surveyed in part three of the questionnaire. We also requested information on the total days of patient contact per student and the clinical year in which the rotations were offered. Table 3 provides a breakdown of required and elective on- and off-campus clinical rotations. While all of the responding institutions have both required and elective rotations through low vision and primary care clinics serving elderly individuals, only two optometry schools had a geriatric specialty clinic. One school indicated required rotations through an adult clinic (over 40 years of age). Twelve schools have required rotations and three elective rotations, through off-campus sites. Off-campus experiences were at a variety of settings: nursing homes, community centers, Veteran's Administration (VA) clinics, senior centers, family practices, hospitals, vision centers, specialty low vision clinics and in-home programs. Only one institution did not offer an off-campus geriatric clinical program. While the clinical rotations were offered in either the third or fourth professional year, the majority of required clinics were for fourth year students. The number of clinical patient contacts ranged from a minimum of four to a maximum of 50 patients/per student/per year, with the average being 12. Information on geriatric residencies was additionally requested. Thirteen residencies were reported: seven were VA hospital-based residencies, two were VA geriatric residencies, three were residencies in VA rehabilitation optometry, and one was listed as a low vision/gerontology residency.

Section four involved active or recently completed projects in or related to vision and aging (Table 4). Only six of the 16 responding schools indicated such research experience. Topics included Type II Diabetes Mellitus Studies, Effects of Ultraviolet Light, Spatial Frequency in Aging, Tear Physiology, Functional Vision with Early Cataracts, Visual Perception with Aging, Maintaining Independence in Institutionalized Older Adults, Long-term Care Curriculum Research, Eccentric Fixation and Senile Maculopathies, and Low Vision Aids Training.

The schools with current or regular continuing education courses on vision and aging are shown in Table 5. Six institutions have programs specific to vision and the elderly. Topics included Vision and Aging, Low Vision and Geriatrics, Age-related Maculopathy and the Management of Various Ocular Problems in Older Adults. The remaining ten schools did not report continuing education courses specific to the aging adult.

Table 6 presents information gathered on public educational activities at each institution. Nine schools indicate active participation in public education/health promotion programs. Specific types of activities and number of schools participating were: education seminars (4), in-service education (2), vision screenings (5), elder hospice (2), public service announcements (2), public relations appearances/interviews (2) and promotional material distribution (2).

The last section of the questionnaire (Table 7) dealt with the optimum method and format of instruction in optometric gerontology. Respondents were asked to prioritize a given list of modes/methodologies. The final rank-ordered instructional methods were: a single, required course (1st); on-campus clinical geriatric training (2nd); age-related content integrated in other coursework (3rd); off-campus clinical experiences

(4th) and a single, elective course (5th).

The final survey data came in response to the question: What are the essential elements and the most appropriate structure of a comprehensive optometric gerontology program? Ten "primary contact" faculty indicated this structure should include, at a minimum, both a separate required course and geriatric clinical experiences. Of these ten, five further specified multidisciplinary elements; one - geriatric specialty clinics; one - an internal geriatric residency program; one - specially trained faculty; one - appropriate labs with coursework; one - in-home eye care and one - public and continuing education programs. Two individuals stressed the importance of multidisciplinary participation and a comprehensive, well-sequenced course. The remaining four respondents did not address this question.

Discussion

While both the Rosenbloom and ASCO survey explored similar topics in optometric gerontology using different questions, some results can be compared. Both surveys requested data on formal optometric gerontology courses offered. The number of schools with formal courses (10) was unchanged as of fall 1986. However, three survey respondents will have implemented separate required courses before winter 1988. Regarding on- and off-campus clinical geriatric rotations, the number of in-house specialty clinics remained the same (3). The Rosenbloom survey gathered data on the types of off-campus clinical activities and did not include information on the frequency of rotations or the number of schools with such programs. In the Rosenbloom survey, off-campus clinical experiences included Screenings, Nursing Homes, VA hospitals (residency rotations), Geriatric Day Care Centers, General or County Hospitals, Mobile Clinic Services, Lighthouse and Vision Centers. Additional sites reported in the ASCO survey included VA Externship Rotations, Specialty Low Vision Clinics and In-Home Eye Care Programs.

At the time of the Rosenbloom survey, there were eight VA residency programs associated with the schools and colleges of optometry. The ASCO survey revealed 13 residencies, an increase of five. The subject of vision and aging research was investigated and revealed that the number engaged in such activity increased from three to six schools and colleges. The number of institutions involved in public educational/health promotional activities also increased from five to seven schools.

TABLE 1

Training of Primary Contact Faculty

# of Faculty	Category of Training/Education
10	No formal training
1	College coursework
3	Geriatric Education Center rotation
1	Certificate
1	Formal degree

TABLE 2

Formal and Separate Optometric Gerontology Coursework

# of Schools	Type of Course
5	No formal course
2	Separate elective course
1	Required course combined with low vision
8	Required, separate course

Note: Three schools indicated the planned implementation of a required separte course by winter 1988.

TABLE 3

Geriatric Clinical Programs

# of Schools	Type of Clinical Activity
	On-Campus
13	No on-campus geriatrics specialty clinic
3	Required on-campus geriatrics specialty clinic rotation
	Off-Campus:
1	No off-campus rotations
3	Elective off-campus geriatrics clinical rotations
12	Required off-campus geriatrics clinical rotations

The area which had decreased in emphasis was continuing education. Rosenbloom reported seven schools with programs in various aspects of vision and aging. The ASCO survey found that the number of schools offering continuing education courses on vision and aging topics had dropped to six.

Summary

The ASCO survey on existing practices among the schools and colleges of optometry revealed a number of important trends. Through comparison with the Rosenbloom survey, it is apparent that academic optometry has begun to respond to the growing need for improved educational experience with aging. This is best evidenced by the increasing number of institutions which teach or will teach geriatrics as a required course in the curriculum and the growing number and type of geriatric clinical training opportunities available.

One notable fact is that the majority of the key individuals in geriatrics at the responding schools have no formal training in gerontology (Table 1). (Note: in scoring responses to this question from the survey, "formal training" was defined loosely. Graduate degrees or certificates in gerontology as well as completion of intensive but short-term training programs at federally funded Geriatric Education Centers were considered "formal training".) Even using this broad definition, very few professors of optometric gerontology had a formal background in the area. This finding most likely reflects the common trend among institutions to combine geriatric training with low vision training. Commonly, geriatric teaching loads and administrative responsibilities are assigned to individuals whose primary interest and expertise is in vision rehabilitation.

At the time of the recent survey, only half (Table 2) of the ASCO member institutions had an existing, required separate course in optometric gerontology. Of the existing courses, none had a laboratory component. In terms of clinical experiences, few institutions maintained an on-campus specialty clinic in which intensive training in unique patient-care aspects of geriatrics could be addressed. While most schools offer off-campus clinical training opportunities, the variety of settings per school and the number of patient contacts per student per year were minimal. The opportunities and requirements for clinical training in geriatrics varied greatly among the various institutions. There is presently little to no consistency in the emphasis given to geriatrics training across the profession.

Optometric institutions have just

TABLE 4

Current Vision and Aging Related Research

# of Schools	Research Projects
10	No projects reported
6	Ongoing or recently completed projects

TABLE 5

Continuing Education Courses on Vision and Aging

# of Schools	CE Programs
6	Vision and aging specific courses
10	No vision and aging specific courses

TABLE 6

Public Educational Activities in Vision and Aging

# of Schools	Activities
7	No active public education activities
9	Public educational activities (8 with students)

TABLE 7

Optimal Mode of Providing Optometric Gerontology Instruction

Rank Order	Instructional Mode
1	Single, required course
2	On-campus clinical geriatrics rotations
3	Age-related material integrated into curriculum
4	Off-campus clinical experiences
5	Single, elective course

begun to realize the unlimited potential that exists in vision and aging research. While six of the 16 responding institutions indicated activity in vision and aging related projects, the majority were indirectly associated with the aging process or the elderly individual. Much more attention needs to be given to this important area of research.

Schools and colleges of optometry are recognized leaders in optometric continuing education. Faculty members and private practitioners should be able to upgrade their skills and knowledge through programs at these institutions. The results of the survey demonstrate that greater attention is needed in developing and offering continuing education courses on a variety of subjects in "optometric gerontology."

The schools and colleges have given greater attention to public education and health promotion activities related to vision and aging. While the institutions active in this area represented a variety of activity types, only one school reported a comprehensive public education/health promotional program. All schools should consider these programs as viable methods for serving their community, for making the profession of optometry more visible, and for educating their students.

Regarding the best single mode of offering optometric gerontology instruction, a required separate course was ranked the highest (with on-campus clinical rotations a very close second). When responding to an open-ended question on the same topic, the overwhelming majority agreed that a combined required clinical and didactic program specific to gerontology was the preferred approach. While it appears that the leaders in geriatrics at the responding schools recognize and, for the most part, agree on the curricular needs and approaches, much work remains to be accomplished.

The ASCO survey strongly agrees with the Rosenbloom survey in pointing out the inadequacies of current optometric gerontology educational programs and activities. Considering the current population trends and demographics, if the identified deficiencies are not addressed, optometrists will be insufficiently trained to properly meet the demands of an aging society.

Recommendations

Based on the inadequacies identified through the ASCO survey, the Committee recommends the following steps:

1. The improvement of opportunities for faculty to receive formal training in optometric gerontology.
2. The assignment of a faculty member in each institution whose primary responsibility would be in the area of optometric gerontology.
3. The upgrading of all college curricula to include a separate, required course in optometric gerontology. The course should be competency based, utilize a multidisciplinary approach and include a laboratory component.
4. Increase the number and type of both on-campus and off-campus clinical geriatric rotations for beginning, intermediate and advanced professional years. The majority of schools need to develop on-campus geriatric specialty clinics. Off-campus programs should be expanded to include screenings, hospital care, nursing home and in-home care. All schools should offer specialized fourth year externships and post-graduation residencies in geriatrics.
5. Administration in schools engaged in research should encourage faculty members to apply for extramural funding basic and applied research on vision and aging, especially in the area of clinical methodology. Schools not currently involved in research should consider this area as a first field of study.
6. The development and implementation, on a regular basis, of continuing education lectures and courses in Optometric Gerontology. Courses should be held on-campus through grand rounds and intensive workshops as well as off-campus at state, regional and national association meetings. Material should include concepts of general gerontology as well as topics specific to vision.
7. The implementation of comprehensive public education/health promotion programs in aging at all schools and colleges of optometry. Activities such as screenings, educational seminars, in-service professional education, public relation interviews and announcements, elder hospice and the distribution of promotional materials should be available. Students should be included in these activities.
8. The development of a model "Optometric Gerontology" program, including didactic and clinical components. This program should be implemented in all ASCO member institutions.
9. The increase in the number and type of "Optometric Gerontology" questions on the National Board Examinations.

Epilogue

The results from the ASCO survey on Optometric Gerontology and the earlier Rosenbloom Survey have already served as an impetus to further develop training programs in optometric gerontology. In November 1986, the ASCO Optometric Gerontology Curriculum Development Committee (Dr. Gary Mancil, Chairperson, University of Alabama at Birmingham College of Optometry; Dr. Sheree Aston, Pennsylvania College of Optometry and Dr. Denise DeSylvia, Ferris State College of Optometry) responded to a request for proposals on professional training in geriatrics from the Administration on Aging. This grant, awarded to ASCO in September 1987, provides for the development of a comprehensive, competency-based program and textbook in optometric gerontology. The modular text will contain summary competencies, detailed educational objectives, experiential exercises, audio-visual materials and resources, a model "clinical geriatrics" program and extensive references and reading lists. Three regional workshops will be conducted during fall 1988 to train key individuals at each of the ASCO member institutions in the usage of the comprehensive program and text. The ASCO Optometric Gerontology Curriculum Development Committee expresses its appreciation to all individuals at the responding institutions who assisted the Committee in its work by completing the survey. The Committee also solicits the continued support of the administration and faculty at ASCO member institutions in completing work on this major project. □

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Deans in the Health Professions: A Comparison of Degrees

Jack E. Terry, O.D., M.S.

Introduction

As the chief administrative officer of a health professional school or college, the dean must be qualified by education and experience to provide leadership in scientific, academic and research activities and in the care of patients.[1] The functioning of the dean will then relate directly and indirectly to the goals of the academic institution. Although the obligations and activities of the schools of the health professions (e.g. optometry, medicine, osteopathy, dentistry, and podiatry) obviously are diverse, their principal charge is uniformly to provide their students with the opportunities and resources to acquire a solid, complete education in the clinical practice of their particular health specialty. The other inherent responsibilities of the schools only serve to reinforce this primary focus. In addition, the building blocks to develop lifelong habits of scholarly reasoning and competent patient care must be promoted by the dean and the faculty. This is imperative in all of the health professions because their respective students are preparing to enter a marketplace that is rapidly changing due to the ever-increasing roles of high technology, heightened competition and rising health care costs.

The many deans of the health professions schools strive to meet the common educational goals in a dynamic, energetic manner. The purpose of this survey is to compare and contrast the professional and graduate level degrees of the deans of the health professions. This comparison may reveal whether there exist any trends which may lend insight into each of the professions' educational systems and their perceptions of their primary educational goals.

Dr. Terry is chief of optometric specialties and director of hospital based optometric residencies at the Huntington, West Virginia, Veterans Administration Medical Center. He is also clinical assistant professor at the Indiana University School of Optometry and adjunct assistant professor at the Pennsylvania School of Optometry.

Method

A survey of all of the major academic health care institutions was undertaken. To contain the scope of the survey, it was decided to include only schools in the United States. A list of all of the current deans of the schools and colleges of each discipline was requested from the appropriate sources. In an effort to maintain the same level of comparison, both inter- and intraprofessionally, the survey included only the highest-ranking dean of each institution (e.g. dean of academic affairs), but not the presidents of the private schools. The review was relatively simple for the smaller health professions (podiatry, osteopathy, and optometry) and more difficult for medicine and dentistry.

The American Podiatric Medical Association forwarded the necessary survey information for each of its seven podiatric institutions.[2] At the time of the request for the data, care was taken to emphasize the importance of an accurate delineation of the degree or degrees that the dean had earned (e.g. D.P.M., M.S., Ph.D., M.P.H., etc.). This written documentation was then confirmed by a telephone call to the dean's office of each institution.

The Council on Optometric Education of the American Optometric Association provided a current listing of accredited, professional, optometric degree programs.[3] Since this list contained the name of the dean at the state-supported institutions and the president of the private schools, personal communication with this latter group accurately verified current deans and degrees.

The 1986 Annual Statistical Report of the American Association of Colleges of Osteopathic Medicine provided both the names and telephone numbers of the schools and colleges of osteopathy.[4] In addition, a recently revised listing of the "Presidents and Deans — Colleges of Osteopathic Medicine" was provided by the same organization.[5] This written information again was verified by personal communication with each institution.

Several sources were used to verify the degrees of the deans of the dental schools. The American Dental Association's Council on Dental Education, in cooperation with The American Association of Dental Schools, supplied a copy of its 1986-87 Annual Report.[6] Table 4 listed the dental schools and their deans. However, instead of listing the deans by degree(s), they all had the title "Dr." placed before their name. Mr. Czarnecki of the CDE kindly supplied their degrees. This information was further corroborated by an individual at the West Virginia School of Dentistry, who provided a list which included each dean and his/her degree(s) for each school.[7] In five cases, the degree(s) had to be finally documented by telephoning the dental institution.

Even though the number of deans of schools and colleges of medicine is significantly higher, the degrees were somewhat easier to establish. A special edition of the *Journal of the American*

Medical Association (JAMA) is published each September in which the current dean at each school is listed.[8] In addition, the Association of American Medical Colleges (AAMC) publishes a listing of the medical schools and their deans.[9] The information was further verified by the current "Dean, Medical School" mailing list that the Marshall University School of Medicine supplied, which lists each dean's degrees. The final check of the medical school deans was provided by the office of Undergraduate Medical Education of the American Medical Association. This office was able to provide the most recent changes in deans across the country.

Results

The results of this survey on the degrees of the deans of the various health professional schools are presented in Table 1. This prevalence comparison table was divided into the various health care professions (i.e. osteopathy, medicine, dentistry, podiatry, and optometry). Each of these professions was divided into categories by the broad type of degrees that their deans possessed (sole professional degree, sole Ph.D., combined master's, combined Ph.D., and others). Figure 1 depicts a portion of this data. For each profession, the solid bar represents the percentage of deans that possesses sole professional degrees (e.g. O.D.), while the lighter bar reveals the percentage that has both the professional degree and a Ph.D. (Combined Ph.D.).

All of the professional schools of osteopathy are headed by deans possessing only the D.O. degree. None had earned a M.S. or Ph.D.

The survey of medical school deans included a total of 125. There were two colleges (University of Illinois and University of Kansas) that had branch campuses with associate deans. In these instances, only the principal dean of the main campus was included in the survey. In medicine, 113 of the 125 deans had only professional degrees (90.4%), two (1.6%) had a Ph.D. degree without a professional degree, nine of the 125 (7.2%) possessed a combined M.D./Ph.D., and there was one dean (0.8%) whose degrees (M.B., B.S.) were classified in the "Others" category.

The academic leadership of dentistry revealed that 15 of the 59 deans (25.4%) had only professional degrees while one (1.7%) had a Ph.D. without a professional degree in dentistry. Ten of the 59 (16.9%) dental school deans had both D.D.S. and Ph.D. degrees, while the majority (30 of 59, or 50.9%) had combined dental and master's degrees. It is relevant to note that the vast majority of dental school deans with master's degrees were in a clinical science specialty such as endodontics, oral pathology, oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics, prosthodontics, and dental public health. Three of the deans had degrees categorized as "Others." These included a B.D.S./Ph.D., as well as an F.E., and an F.E./Ph.D.

The survey of optometry school deans showed that one of the fifteen (6.7%) in the study had only the O.D. degree, while there was also only one (6.7%) with a Ph.D. but without the professional degree. Five of fifteen deans (33%) had combined O.D. and master's level degrees (M.S., M.P.H., or M.P.A.). The largest group of deans in optometry was found to have combined O.D. and Ph.D. degrees (7 of 15, or 46.7%). There was only one dean characterized in the "Others" category (O.D., M.D.).

Four of the seven podiatry deans were found to have sole professional degrees of D.P.M., while two of the seven (28.6%) had sole Ph.D. degrees without the professional degree. One dean (14.3%) of a college of podiatry had combined professional/master's degrees (i.e. D.P.M., M.P.H.).

Table 2 further divides the deans into two categories. The first column includes the percentage of deans of each profession who possessed a sole professional degree or a professional degree and a master's level degree. The second column includes the percentage of deans who had either a sole Ph.D. or who had attained a combined professional degree and Ph.D. This data is diagrammed in Figure 2.

TABLE 1

Prevalence Comparison of U.S. Professional School Deans

	Sole Professional Degree	Sole Ph.D.	Combined Masters	Combined Ph.D.	Others
Osteopathy	100.0%				
Medicine	90.4%	1.6%		7.2%	0.8%
Dentistry	25.4%	1.7%	50.9%	16.9%	5.1%
Podiatry	57.1%	28.6%	14.3%		
Optometry	6.7%	6.7%	33.3%	46.7%	6.7%
OVERALL	67.0%	2.7%	16.3%	11.8%	1.8%

TABLE 2

Prevalence Comparison of U.S. Professional School Deans

	Sole Professional/ Combined Masters	Sole Ph.D./ Combined Ph.D.
Osteopathy	100.0%	
Medicine	90.4%	8.8%
Dentistry	76.3%	18.6%
Podiatry	71.4%	28.6%
Optometry	40.0%	53.4%
OVERALL	83.3%	13.6%

Discussion

As diverse as the health professional deans were by nature of their educational background, interests and goals, a number of similarities existed.

Individuals sporting only a Ph.D., without an accompanying professional degree, were very infrequently chosen as dean. Overall, only six of 221 professional school deans (2.7%) had just a Ph.D. This finding is not unexpected

when one considers the type of clinical background, experience and expertise that a dean should possess in order to bring the necessary excellence to a health professions education. Obviously, the number of individuals who can offer this type of leadership to a professional school without a corresponding professional background must be relatively small. Therefore, the most populated category of deans in this study included those who had attained simply a professional degree (67.0%). Medicine and osteopathy were headed by the highest percentages (90.4 and 100%, respectively) of sole professional degree deans, while optometry had the fewest (6.7%).

The second largest category (16.3%) of professional school deans possessed both a professional degree and master's level degree. This phenomenon was particularly noteworthy in dentistry, where 50.9% had both a D.D.S. and M.S. As was discussed earlier in this report, these degrees were largely earned in post-graduate clinical science education. Optometry had the second-largest percentage of combined master's level deans (33.3%). Podiatry had 14.3% of combined master's level deans while medicine and osteopathy had none.

One of the most striking differences among the professions was found in the category of the deans who possessed both a professional degree and a Ph.D. Overall, only 11.8% of all professional school deans have both a professional degree and Ph.D. In medicine and dentistry, the percentage is relatively low (7.2 and 16.9%, respectively), whereas the results of the survey found 46.7% of optometry school deans possessing both degrees.

Conclusion

Overall, the vast majority of professional school deans possessed either a single professional degree (67.0%) or combined professional/master's level degrees (83.3%). Only 2.7% had just a Ph.D. while 11.8% possessed both a combined professional degree and Ph.D. Optometry had the largest percentage of combined Ph.D.'s (46.7%) and the lowest percent of single professional degree (6.7%) deans compared to the professions surveyed. Osteopathy had the highest percent (100%) of single professional degree deans, and with podiatry, had the lowest percent (0.0%) of combined Ph.D. degree deans. □

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FIGURE 1

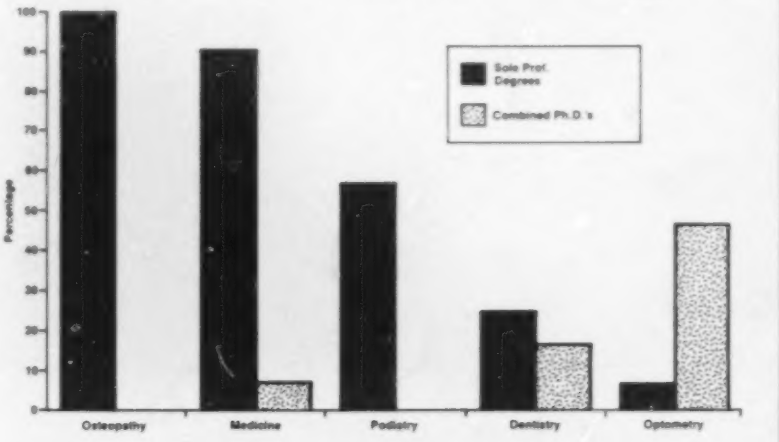

FIGURE 2